

## PATIENT INTAKE

Name: \_\_\_\_\_ (Age) \_\_\_\_\_ Gender: M F  
Home Address: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_  
Email Address: \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_  
Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Marital Status: S M D W  
Names of Children: \_\_\_\_\_ Ages: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer Name: \_\_\_\_\_  
Spouse's Name: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_  
Spouse's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
How were you referred to this office? \_\_\_\_\_

## PURPOSE OF THIS VISIT

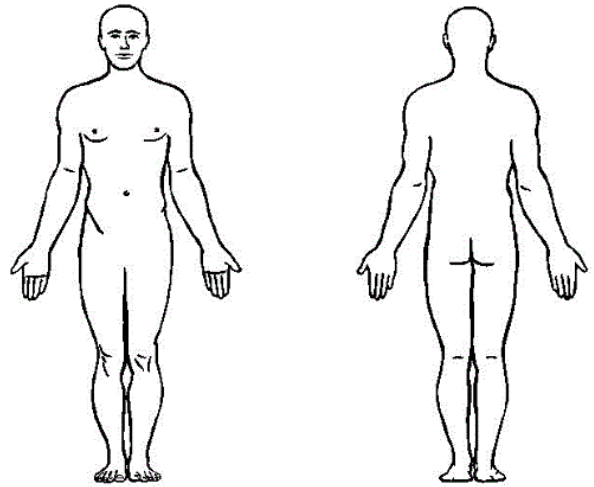
Reason for this visit: \_\_\_\_\_  
Is this purpose related to an auto accident / work injury? Yes No If so, when: \_\_\_\_\_  
Describe: \_\_\_\_\_  
Please describe the pain & its location: \_\_\_\_\_  
Indicate your current level of pain from 0 (No Pain) to 10 (Excruciating): 0 1 2 3 4 5 6 7 8 9 10  
When did this condition begin? \_\_\_\_/\_\_\_\_/\_\_\_\_ When did you first notice it? \_\_\_\_\_  
Is this condition getting worse? Yes No Is this condition: Constant Comes & goes Activity related  
Does complaint(s) interfere with: \_\_Work \_\_Sleep \_\_Hobbies \_\_Daily Routine Explain: \_\_\_\_\_  
What activities aggravate your symptoms? \_\_\_\_\_  
Is there anything, which has relieved your symptoms? Yes No Describe: \_\_\_\_\_  
Have you experienced this condition before? Yes No If so, please explain: \_\_\_\_\_  
Have you had treatment anywhere else for this condition? Yes No What type of treatment? \_\_\_\_\_

## EXPERIENCE WITH CHIROPRACTIC

Have you seen a Chiropractor before? Yes No Who? \_\_\_\_\_ When? \_\_\_\_\_  
Reason for visits: \_\_\_\_\_  
How did you respond? \_\_\_\_\_  
Did your previous chiropractor take x-rays before or after? Yes No  
Did you know posture determines your health? Yes No  
Are you aware of any of your poor posture habits? Yes No  
Explain: \_\_\_\_\_

Please use the diagram to indicate where you experience pain and discomfort and the type of pain or discomfort following the key below:

- A – Dull/ache
- N – Numbness
- T – Tingling
- S – Sharp or Stabbing
- B – Burning
- St – Stiffness
- Th- Throbbing
- D – Deep
- C- Cramping



## HEALTH CONDITIONS

Please indicate if you currently have or have a history of any of the following injuries or illnesses.

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Headaches              | <input type="checkbox"/> Neck Pain                      | <input type="checkbox"/> Allergies/Sinusitis             | <input type="checkbox"/> Dizziness             |
| <input type="checkbox"/> Migraines              | <input type="checkbox"/> Pain into shoulders/Arms       | <input type="checkbox"/> Numbness/Tingling in Arms/Hands | <input type="checkbox"/> Grip Weakness         |
| <input type="checkbox"/> TMJ Pain/clicking      | <input type="checkbox"/> Low Energy/Fatigue             | <input type="checkbox"/> Visual or Hearing Trouble       | <input type="checkbox"/> Mid Back Pain         |
| <input type="checkbox"/> Pain around ribs/chest | <input type="checkbox"/> Indigestion/Heartburn          | <input type="checkbox"/> Nausea                          | <input type="checkbox"/> Asthma/Wheezing       |
| <input type="checkbox"/> Shortness of Breath    | <input type="checkbox"/> Heart Conditions _____         | <input type="checkbox"/> Diabetes                        | <input type="checkbox"/> Ulcers/Gastritis      |
| <input type="checkbox"/> Low Back Pain          | <input type="checkbox"/> Numbness/Tingling in Legs/Feet | <input type="checkbox"/> Pain into Hips/legs/feet        | <input type="checkbox"/> Weakness in legs/feet |
| <input type="checkbox"/> Constipation/Diarrhea  | <input type="checkbox"/> Cramping in legs/feet          | <input type="checkbox"/> Cold hands/feet                 | <input type="checkbox"/> Frequent urination    |
| <input type="checkbox"/> Scoliosis              | <input type="checkbox"/> Thyroid Conditions             | <input type="checkbox"/> Dislocations/Fractures          | <input type="checkbox"/> Cancer                |
| <input type="checkbox"/> “Hump” at base of neck | <input type="checkbox"/> Hives/Eczema                   | <input type="checkbox"/> Arthritis                       | <input type="checkbox"/> Varicose Veins        |

Women Only:  Menstrual Irregularities      Currently Pregnant?   Yes   No

Please list any conditions not mentioned: \_\_\_\_\_

Please list any medications / surgeries: \_\_\_\_\_

Have you ever had any injuries to your spine?   Yes   No

## HEALTH LIFESTYLE

Do you exercise?    Yes   No    How often? 1X 2X 3X 4X 5X per week other: \_\_\_\_\_

What activities? Running Jogging Weight Training Cycling Yoga Pilates Swimming Other: \_\_\_\_\_

Do you smoke?      Yes   No    How much? \_\_\_\_\_

Do you drink alcohol? Yes   No    How much / week? \_\_\_\_\_

Do you drink coffee? Yes   No    How many cups / day? \_\_\_\_\_

Do you take any supplements (i.e. vitamins, minerals, herbs)? \_\_\_\_\_

## FAMILY HEALTH HISTORY

Have any of your family members ever been diagnosed with the following?

- |   |                                       |                                     |   |  |
|---|---------------------------------------|-------------------------------------|---|--|
| <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Cancer       | <input type="checkbox"/> Stroke     | <input type="checkbox"/> Heart Disease/Heart Attack | <input type="checkbox"/> Measles         |
| <input type="checkbox"/> Varicose Veins     | <input type="checkbox"/> Polio        | <input type="checkbox"/> Mumps      | <input type="checkbox"/> Neurological Conditions    | <input type="checkbox"/> Kidney Disease  |
| <input type="checkbox"/> Liver Disease      | <input type="checkbox"/> Eczema       | <input type="checkbox"/> Depression | <input type="checkbox"/> Infectious Diseases        | <input type="checkbox"/> Tuberculosis    |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Arthritis  | <input type="checkbox"/> Dementia/Alzheimers        | <input type="checkbox"/> Lung Conditions |

Other: \_\_\_\_\_

## RADIOGRAPH CONSENT

I \_\_\_\_\_ do hereby give my consent to allow this office and its representatives, as deemed by the examining physician to take radiographs of my spine and/or extremities.

I also hereby declare that to my knowledge that I am not pregnant \_\_\_\_\_ ( Initial )

Signature of Patient/or Guardian of said Minor \_\_\_\_\_ Date \_\_\_\_\_

## IN CASE OF EMERGENCY

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Work Phone \_\_\_\_\_

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

## AUTHORIZATION OF CARE and INFORMED CONSENT

I authorize and agree to allow the doctor(s) and/or physical therapist to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal biomechanical and neurological function. I acknowledge and understand that even though negative results are rarely experienced, as with any form of treatment they are possible. Some of the potential risks may include but are not limited to: fractures, worsening of symptoms, muscle injury, joint irritation/dislocation. I recognize it is my responsibility to inform of the doctor of any and all conditions that may affect my care.

Although no significant data shows a correlation between chiropractic adjustments and the cause of stroke, I understand that there is concern in certain situations and if I have questions I agree to consult with my doctor. In the uncommon case that negative results from treatment occur at any time, I will notify the doctor immediately so that proper treatment can be administered and the result noted for future reference.

It is with full understanding and acknowledgment that I authorize and agree to the recommended course of treatment for conditions related to my spine and joints as prescribed by my doctor in this office.

I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.

The Doctor and/or physical therapist will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions diagnosed at this clinic.

I also clearly understand that if I do not follow the doctors and/or physical therapist specific recommendations at this clinic that I will not receive the full benefit from these programs, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time.

I authorize the assignment of all insurance benefits be directed to the doctor and/or physical therapist for all services rendered.

\_\_\_\_\_  
Patient's Name Printed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Minors Name

\_\_\_\_\_  
Guardian/Spouse's Signature of Authorizing care for minor

\_\_\_\_\_  
Date

## INSURANCE INFORMATION

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. The Doctors office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

I understand there could be some services that my insurance company does not cover, if this is the case are you willing to pay for these services? YES NO (please circle)

Patients Signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian or Spouse's Signature Authorizing Care \_\_\_\_\_ Date \_\_\_\_\_

\*I hereby authorize Dr. Kevin Morford, Dr. Brenda Hooper, Dr. April Morford and/or Dr. Ryan Hooper to administer care as deemed necessary to my child, a minor under the age of 18 years old.

### Please only fill out the following information if we have not received a copy of your insurance card

Name of Insurance Co. \_\_\_\_\_ Policy# \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

Insured's Name \_\_\_\_\_ Insured's SS# \_\_\_\_\_

Relationship to Insured \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer \_\_\_\_\_

### Who should receive charges on your account?

Patient    Spouse    Parent/Guardian    Workers Comp    Auto Insurance    Personal Health Insurance

The Chiropractic Offices of  
Dr. Brenda Hooper, Dr. Kevin Morford, Dr. April Morford & Dr. Ryan Hooper  
520 W. 15<sup>th</sup> St. Edmond, OK 73013  
(p) 405.844.4492 (f) 405.341.8291

## ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I, \_\_\_\_\_, have been made aware of and/or received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and accreditation.

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Patient

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Signature

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Date

### For Office Use Only

**We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:**

- Individual refused to sign
- Communications barriers prohibited obtaining the Acknowledgment
- An emergency situation prevented us from obtaining Acknowledgment
- Other (Please Specify) \_\_\_\_\_

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Staff signature

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Date